MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 5, 2016

[redacted]

IBR Case Number:	CB16-0000024	Date of Injury:	02/26/2013
Claim Number:	[redacted]	Application Received:	01/05/2016
Claims Administrator:	[redacted]		
Date(s) of service:	10/13/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	64635		

[redacted]:
MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above workers' compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $195.00 for the review cost and $674.93 in additional reimbursement for a total of $869.93. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $869.93 within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

Paul Manchester, MD, MPH
Medical Director
cc: [redacted]

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- Official Medical Fee Schedule
- Negotiated contracted rates: PPO Discount 10%
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE**: Provider is dissatisfied with reimbursement of $1350.37 for code 64635 performed on 10/13/2015
- 64635 - Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
- Section 9789.33. Determination of Maximum Reasonable Fee: (a) In accordance with section 9789.32, the maximum allowable payment for outpatient facility fees for hospital emergency room services, surgical services, or for Facility Only Services performed at a hospital outpatient department, or for surgical services performed at an ambulatory surgical center shall be determined based on the following. In accordance with Section 9789.30(aa), an extra percentage reimbursement shall be used in lieu of an additional payment for high cost outlier cases.
- For services rendered on or after September 1, 2014: APC relative weight x adjusted conversion factor x 1.212 workers' compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative
- PPO contract was not submitted for review.
- Based on OPPS reimbursement for 64635, 21.2609 x 87.33 x 1.212 = $2250.34 due to Provider.

- Provider states a 10% discount is to be applied to reimbursement along with multiple procedure reduction.
- Opportunity for Claims Administrator to Dispute letter sent on 1/7/2016. A response from Claims Administrator was not received for this review.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code 64635 is recommended

Date of Service: 10/13/2015						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
64635	$3,246.00	$1350.37	$674.94	100%	$2025.30	**DISPUTED SERVICE**: Allow reimbursement $674.93

Copy to:

[redacted]

Copy to:

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